Local No. 9, IBEW and Outside Contractors Health and Welfare Fund

Family Status Change Form and Confirmation of Other Medical Coverage

Member Information

NAME (FIRST, MIDDLE, LAST) (MAIDEN)

SOCIAL SECURITY NUMBER	BCBS ID NO. on Member's BCBS card BWL	**DATE OF BIRTH (MM/DD/YYYY)**
STREET ADDRESS	CITY	STATE ZIP
EMAIL	HOME PHONE include area code	MOBILE PHONE include area code

MARITAL STATUS Check one: ☐ Single ☐ Married Date: Month / Day / Year ☐ Divorced Date: Month / Day / Year ☐ Widowed Date: Month / Day / Year

IS MEMBER ON MEDICARE? ☐ Yes ☐ No	If yes, Medicare Claim No.		
If yes, Medicare Part A effective date	If yes, Medicare Part B effective date	If yes, Medicare Part C effective date	If yes, Medicare Part D effective date

DOES MEMBER HAVE HEALTH CARE COVERAGE UNDER ANY OTHER PLAN, INCLUDING ANY MEDICARE SUPPLEMENT? ☐ Yes ☐ No If yes, complete the rest of this section

NAME OF PLAN	POLICYHOLDER'S NAME	POLICYHOLDER'S ID NUMBER
GROUP OR PLAN NUMBER	TYPE OF COVERAGE IN THIS PLAN (check all that apply): ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ DRUG	

Spouse Information

NAME (FIRST, MIDDLE, LAST)	**SOCIAL SECURITY NUMBER**
DATE OF BIRTH (MM/DD/YYYY)	MAILING INFORMATION ☐ Check here if mailing address is the same as the Member's mailing address. If different, please provide below.
STREET ADDRESS	CITY STATE ZIP
EMAIL HOME PHONE include area code	MOBILE PHONE include area code

IS SPOUSE ON MEDICARE? ☐ Yes ☐ No	If yes, Medicare Claim No.		
If yes, Medicare Part A effective date	If yes, Medicare Part B effective date	If yes, Medicare Part C effective date	If yes, Medicare Part D effective date

DOES SPOUSE HAVE COVERAGE UNDER ANY OTHER PLAN, INCLUDING ANY MEDICARE SUPPLEMENT or an EMPLOYER? ☐ Yes ☐ No If yes, complete the rest of this section

NAME OF PLAN	POLICYHOLDER'S NAME	POLICYHOLDER'S ID NUMBER
GROUP OR PLAN NUMBER	TYPE OF COVERAGE IN THIS PLAN (check all that apply): ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ DRUG	
PHONE NUMBER	CLAIM MAILING ADDRESS	

Wait! You must report children on the reverse side of this form

IF MEMBER HAS MORE THAN 3 CHILDREN, PLEASE PROVIDE INFORMATION ON A SEPARATE SHEET OF PAPER (you may copy this form).

If member is **adding a spouse or child dependent(s) under the age of 18** via this form, a copy of an original or certified copy of the county- or state-issued marriage license (if adding a spouse) or a copy of the original county- or state-issued birth certificate with the member named as the parent (if adding a child) must accompany this form. To **add an adult child dependent 18 years or older**, you cannot do so with this form; instead you must submit the **Special Adult Child Enrollment Form** (download from www.myfundorrfice.com or request the form from the Fund Office). If **terminating spousal or dependent coverage** you must request and submit a **Dependent Dis-Enrollment Form**.

I hereby confirm that the information provided on this form is true and correct:

MEMBER SIGNATURE DATE

Return this form to: Local 9, IBEW and Outside Contractors Health and Welfare Fund, 18670 Graphics Drive, Ste 201, Tinley Park, IL 60477 Direct inquiries to 866-661-1021, option 0.

Child 1

NAME (FIRST, MIDDLE, LAST)

SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM/DD/YYYY)

MAILING INFORMATION ☐ Check here if mailing address is the same as the Member's mailing address. If different, please provide below.

STREET ADDRESS | CITY | STATE | ZIP

EMAIL | HOME PHONE include area code | MOBILE PHONE include area code

IS CHILD ON MEDICARE? ☐ Yes ☐ No

MEDICARE CLAIM NO.

If yes, Medicare Part A effective date | If yes, Medicare Part B effective date | If yes, Medicare Part C effective date | If yes, Medicare Part D effective date

DOES CHILD HAVE HEALTH CARE COVERAGE UNDER ANY OTHER PLAN, INCLUDING THE NON-MEMBER PARENT, THE CHILD'S SPOUSE OR DOMESTIC PARTNER, OR ANY MEDICARE SUPPLEMENT?

☐ Yes ☐ No If yes, complete the rest of this section

NAME OF PLAN | POLICYHOLDER'S NAME | POLICYHOLDER'S ID NUMBER

GROUP OR PLAN NUMBER | TYPE OF COVERAGE IN THIS PLAN (check all that apply): ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ DRUG

PHONE NUMBER | CLAIM MAILING ADDRESS

Child 2

NAME (FIRST, MIDDLE, LAST)

SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM/DD/YYYY)

MAILING INFORMATION ☐ Check here if mailing address is the same as the Member's mailing address. If different, please provide below.

STREET ADDRESS | CITY | STATE | ZIP

EMAIL | HOME PHONE include area code | MOBILE PHONE include area code

IS CHILD ON MEDICARE? ☐ Yes ☐ No

MEDICARE CLAIM NO.

If yes, Medicare Part A effective date | If yes, Medicare Part B effective date | If yes, Medicare Part C effective date | If yes, Medicare Part D effective date

DOES CHILD HAVE HEALTH CARE COVERAGE UNDER ANY OTHER PLAN, INCLUDING THE NON-MEMBER PARENT, THE CHILD'S SPOUSE OR DOMESTIC PARTNER, OR ANY MEDICARE SUPPLEMENT?

☐ Yes ☐ No If yes, complete the rest of this section

NAME OF PLAN | POLICYHOLDER'S NAME | POLICYHOLDER'S ID NUMBER

GROUP OR PLAN NUMBER | TYPE OF COVERAGE IN THIS PLAN (check all that apply): ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ DRUG

PHONE NUMBER | CLAIM MAILING ADDRESS

Child 3

NAME (FIRST, MIDDLE, LAST)

SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM/DD/YYYY)

MAILING INFORMATION ☐ Check here if mailing address is the same as the Member's mailing address. If different, please provide below.

STREET ADDRESS | CITY | STATE | ZIP

EMAIL | HOME PHONE include area code | MOBILE PHONE include area code

IS CHILD ON MEDICARE? ☐ Yes ☐ No

MEDICARE CLAIM NO.

If yes, Medicare Part A effective date | If yes, Medicare Part B effective date | If yes, Medicare Part C effective date | If yes, Medicare Part D effective date

DOES CHILD HAVE HEALTH CARE COVERAGE UNDER ANY OTHER PLAN, INCLUDING THE NON-MEMBER PARENT, THE CHILD'S SPOUSE OR DOMESTIC PARTNER, OR ANY MEDICARE SUPPLEMENT?

☐ Yes ☐ No If yes, complete the rest of this section

NAME OF PLAN | POLICYHOLDER'S NAME | POLICYHOLDER'S ID NUMBER

GROUP OR PLAN NUMBER | TYPE OF COVERAGE IN THIS PLAN (check all that apply): ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ DRUG

PHONE NUMBER | CLAIM MAILING ADDRESS

More than 3 children to report? Please copy this page to report them

To prevent denial of claims, submit this completed form asap.

If this form is not filled out in its entirety it will be sent back to you to be completed.